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Implementing family systems nursing through a participatory, circular knowledge-to-action research approach in women's health

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Abstract: Background: Moving towards more family-centred care cultures in acute settings requires attention to the relational connectedness in which persons who seek acute care are situated. To promote such a family-centred culture and to shift the systemic approach to care from an individual one to a relational one, there is a need to integrate family nursing knowledge and skills into everyday acute care practices. Aim: The aim of this knowledge-to-action project was to create a family-centred care culture by integrating a family system nursing approach into clinical practice within the women's health division in an acute care hospital. Methods: An action research methodology, using the action cycle of look-think-act, was used to guide knowledge translation and to develop a family-centred practice culture. The 'think' phase entailed an ongoing, critical dialogue among the study's core group members about the meaning of family systems nursing, a shared definition and adaptation of the approach and instruments to the local context, and the development of an action plan for implementation. Lastly, family systems nursing was interprofessionally piloted through education and training activities in neonatal intermediate care. Findings: During the 'look' phase, 20 SWOT analyses with 312 health professionals revealed a shared commitment to individualised, participatory care, but a lack of continuity and inconsistent communication. Documentary analysis demonstrated that family engagement was evident in fewer than half of the cases. Conclusions: The use of a participatory, recursive process to tailor and introduce family systems nursing was important in order to gain momentum for change across different units and professions. A shared vision, leadership commitment, participatory collaboration and facilitation were essential for the change process, while the diversity of practice settings and scope of the project were the main challenges to starting the culture change required to achieve family-centred care.

DOI: <https://doi.org/10.19043/ipdj.92.005>

Posted at the Zurich Open Repository and Archive, University of Zurich

ZORA URL: <https://doi.org/10.5167/uzh-180464>

Journal Article

Published Version



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Originally published at:

Kläusler-Troxler, Marianne; Petry, Heidi; Lanter, Regula; Naef, Rahel (2019). Implementing family systems nursing through a participatory, circular knowledge-to-action research approach in women's health.

International Practice Development Journal, 9(2):5.
DOI: <https://doi.org/10.19043/ipdj.92.005>

Introduction

A move towards family-centred care cultures requires attention to the relational connectedness in which persons who seek acute care services are situated (Doane and Varcoe, 2013; Segaric and Hall, 2015). Family-centred care has been defined as a philosophy of care that aims to engage and support families through a mutually respectful, relational nurse-family partnership and collaboration (Mikkelsen and Frederiksen, 2011; Cartagena et al., 2012). As such, there is a mounting recognition of the need to promote care structures and processes that embrace family-centred values and principles such as partnership, shared-decision making, and inclusion not only of individual patients but of their family members (Carman et al., 2013; Brown et al., 2015; Institute for Patient- and Family-Centred Care, 2017). The engagement and support of families as an interrelating connectedness (Parse, 2009; Bell, 2011) takes a relational stance and recognises that illness and hospitalisation have rippling effects on family systems, whereas individuals' experiences of illness and care are also constituted by family processes and responses. Family systems nursing is a specific approach to care that focuses on a relational partnership with families, builds on specific family nursing assessment and intervention knowledge and skills, and includes offering family nursing interventions that improve family wellbeing and health (Chesla, 2010; Bell, 2013; Wright and Leahy, 2013). Family systems nursing addresses the needs of families and individual members, using strength-based, relational intervention modalities to support families' capacity in living with illness and care demands, and to ease their suffering (Wright and Bell, 2009; Gottlieb, 2012; Wright and Leahy, 2013). As such, family systems nursing moves beyond creating family-centred care environments and processes alone, as it entails a participatory, relational nurse-family engagement to offer psycho-educational and relationship-focused interventions to family groups and individuals (Shields, 2010; Bell, 2011; 2013).

While there is mounting evidence of the benefits of family systems nursing (Chesla, 2010; Östlund and Persson, 2014), translating theoretical and empirically based knowledge around partnering with and supporting families into practice has lagged behind (Leahy and Svavarsdottir, 2009; Bell, 2013). Barriers to knowledge translation include: the chasm between theory/academia and practice/clinical settings; structures and processes within acute care organisations; lack of interprofessional, collaborative care delivery; and health professionals' lack of knowledge and skills in working with families (Duhamel, 2010; Duhamel et al., 2015). An understanding of knowledge translation as a participatory, inclusive and circular process that engages researchers, practitioners and users alike has been put forward as essential for creating care delivery systems that meet the health and social care needs of people – both individuals and families (Baumbusch et al., 2008; Hartrick Doane et al., 2015). In a similar vein, McCormack and McCance (2006) proposed a framework for developing more effective, safe, person-centred care systems that acknowledges the centrality of context, mutual learning, plurality of methods and skilled facilitation of transformations at the interface of care, based on an organisational commitment to collaborative, inclusive, and participative ways of engaging teams. Thus, developing acute care systems that enable 'good' practices with families entering and moving through hospitals not only requires a culture shift from an individual focus to a relational, family-centred one, but the integration of specific family systems nursing and care knowledge and skills into everyday acute care practice. In this respect, the use of a collaborative, inclusive and participatory approach to system change and circular understanding of knowledge translation is pivotal. This article reports on the methodology, insights and experiences with a family system nursing knowledge-to-action project.

Aims

The overall aim of the knowledge-to-action project was to create a family-centred culture by integrating a family systems approach into clinical practice and interprofessional working with families in the context of women's health (Wright and Leahy, 2013). Moreover, it aimed to effect the desired practice change through the use of a participatory, inclusive and circular knowledge-to-action process that would enable practitioners to enact and sustain systemic and collaborative working with families (Duhamel, 2010; McCormack et al., 2013). The ultimate goal of this initiative was consistently to meet families' needs across the continuum of care and to build their capacity for living with their health challenge or post-acute phase in their everyday lives (Gröning et al., 2015).

Methodology

The project reported here took place from 2015 to 2017 in the department of women's health and newborn care of a major university hospital in the German-speaking part of Switzerland. The hospital's women's health department includes 163 inpatient beds, 7 units, and 349 nurses and midwives. It covers the full range of women's health, including gynaecology, obstetrics and neonatal care. The project was initiated by a senior clinical nurse specialist together with the senior nursing leadership team. A core group was formed of five nurses and one midwife representing the different clinical areas, and complemented with clinic-specific implementation teams representing nurses, physicians and/or midwives.

An action research methodology (Stringer, 2013), together with the principles of collaboration, participation, and inclusion (McCormack et al., 2013) were chosen to guide family systems nursing knowledge translation because they provide mutually congruent and complementary approaches to build effective relationships, which then enable culture and practice changes within healthcare (Manley, 2017). Action research is a process of inquiry that uses a circular process of look-think-act (Stringer, 2013) and can place a focus on appreciative inquiry (Ludema et al., 2010). Its purpose is to provide a set of strategies that enable healthcare professionals to enact a change process in a stepwise, inclusive, shared manner, and to develop effective practices that achieve positive outcomes for patients and their families (Stringer, 2013; Gröning et al., 2015). It is underpinned by a philosophy of emancipatory action, which starts with the development of shared purposes, values and key activities that enable those who are most affected by a change to actualise and own it (Dewar et al., 2017). It is particularly well suited for use in the context of social practices, such as healthcare (Cordeiro and Soares, 2018).

The aim of the 'look' phase is to explore the issue at stake to gain an in-depth understanding of values and practices; that is, how things are currently done (Stringer, 2013). To this end, an analysis of strengths, weaknesses, opportunities, and threats (SWOT), a documentary analysis of patient records, and a consultation of pertinent literature were undertaken (Kaplan and Norton, 2001). A total of 20 SWOT analyses were conducted with 312 health professionals by four core group members from August to November 2015, to engage as many healthcare professionals as possible early on in the change process. The guiding question was: 'How do we involve family groups and individual members in day-to-day care delivery?' (See Table 1). At first, three SWOT analyses were carried out with representatives of different professional groups, such as nurses, midwives, physicians, social workers and therapists, followed by 17 SWOT analyses with unit-based, interprofessional teams. The data gathered were collated and analysed by the first author. SWOT analyses were evaluated for similarities and differences, and then combined into a synthesised, overall SWOT analysis that included core statements (Flick et al., 2009).

Table 1: Questions guiding SWOT analyses

Strengths	Weaknesses
<ul style="list-style-type: none"> • What are we doing well? • What are our strengths? • Which resources do we already have in caring for families? 	<ul style="list-style-type: none"> • What are we doing less well? • Where do we see our weaknesses? • What resources do we need to increase our ability to care for families?
Opportunities	Threats
<ul style="list-style-type: none"> • Where are our chances of achieving effective and sustainable change? • What opportunities does moving towards family-centredness involve, and how can we act on them? • How can this practice change support us in daily interactions with families? 	<ul style="list-style-type: none"> • What inhibits us from involving families and individual members in care? • What prevents families and individual members from being involved in care? • What are the concerns and worries surrounding the practice change? • What risks exist when we enact a family-centred approach to care?

To ascertain how health professionals currently assess families' needs, involve them in care processes and offer supportive interventions, a documentary analysis of 136 patient records was carried out by five core group members in January 2016. The aim was to assess how and when families were involved in care planning, decision making and care delivery, particularly during intake and discharge assessment. The core group developed a structured extraction form (see Table 2), which was pre-tested with 15 cases, and subsequently adapted.

Table 2: Indicators and questions for documentary analysis of clinical records
Psychosocial intake nursing assessment
% of patients with a psychosocial intake nursing assessment <ul style="list-style-type: none"> • Was the intake assessment completed within 24 hours of admission? • Were all aspects addressed (wellbeing, coping strategies, social situation, preferences)? • Was a family member present/included? If so, who? • Has a next-of-kin/contact person been identified and contact details documented?
Follow-up family assessment/conversations
% of patients with a follow-up conversation with a family member % of patients with a planned referral for additional psychosocial support
Discharge planning
% of patients with documented discharge planning activities % of patients with identified need for post-discharge support <ul style="list-style-type: none"> • Need for informal/formal support • Availability of family support • Referrals made to services

To consult existing evidence, the core group reviewed pertinent literature around the effect and implementation of family systems nursing (Martinez et al., 2007; Chesla, 2010; Duhamel, 2010; Östlund and Persson, 2014; Persson and Benzein, 2014; Svavarsdottir et al., 2015). A tabular overview was prepared so that the insights from the reviewed publications could be incorporated into the next action cycles.

Next, during the 'think' phase (January to August 2016), insights from the clinical document analysis and the SWOT analyses were reviewed together with the pertinent literature to reach a shared interpretation of the issues at stake (Stringer, 2013). The gathered and compiled data were used to stimulate a discussion within the core group and interprofessional, unit-based teams, with the aim of developing an interprofessionally shared value base and vision around a family systems approach to care (Laird et al., 2015). The core group then defined the department's approach to family systems nursing and care delivery by drawing on the Calgary Family Nursing Assessment Intervention Models (Wright and Leahey, 2013) and the insights from the 'look' phase. They also planned implementation strategies.

Finally, during the 'act' phase, the actual implementation of the change (Stringer, 2013) – in this case, the shift from an individually focused to a family systems approach to care provision – was effectuated in one clinical area (December 2016 – August 2017), and followed by implementation into the other two clinical areas in 2018 (not reported here).

Project initialisation: building momentum for culture change

Changing healthcare practices requires the involvement of those most affected in the change process (Rycroft-Malone et al., 2004). This can be achieved by focusing on a shared vision and opportunities for emancipatory actions, rather than problems or deficits, to bring forth peoples' potential to make changes (Manley and McCormack, 2003; McCormack and McCance, 2017). Thus, in the very early

stage of the project, the commitment and support of senior nursing leadership in the women's health department was obtained, and a core group of facilitators was formed. This core group developed project goals and ways of collaborating as a team of facilitators, to guide the change process and to create a sense of common purpose. As such, each member of the core group was enabled to take on a facilitator role in their clinical area (Manley and McCormack, 2003).

First, the core group developed the overarching goals for the knowledge-to-action project. In so doing, its aim was to achieve a change of values and beliefs from a more individualistic, patient-focused approach to care delivery to a systemic, relational approach. Hence, the person as patient together with his or her family, or the (preterm, ill) newborn and his or her parents, was defined as the unit and recipient of care. An awareness of the centrality of families in illness and healthcare was to be strengthened through the development of shared values across clinical settings. Another goal was to base family interventions on a position of impartiality, neutrality and respect for families' preferences and decisions. Last, strengthening relationship-building, trust, empathy and communication strategies was seen as central to everyday, collaborative caring practices with families.

Next, the core group set up collaboration guidelines to facilitate the practice change. The agreed rules included mutual trust, openness to each other, confidentiality, tolerance, and a supportive environment. Moreover, the group members wanted it to be recognised that their engagement in the initiative had to occur alongside other responsibilities, and that available resources and expertise had to be taken into consideration (Manley, 2004).

The core group then devised an action plan (Dewing, 2008), which defined the activities within the change process. A detailed time schedule displayed the planned activities under each project phase. In addition, the facilitators of each activity were named. At each core group meeting, the action plan was reviewed and updated. The plan served as a guide and allowed progress to be monitored. As such, it created transparency and enabled a shared responsibility and participation involving all core group members and stakeholders.

'Look' phase: understanding current practices and concerns

The synthesised findings of the SWOT analyses revealed healthcare professionals' perspectives around the intended move towards family systems nursing and care. Professionals identified their strong commitment across professions and units to provide comprehensive, individualised care to women, newborns and their families as a great strength. The psychosocial nursing intake assessment, which had been introduced five years earlier, was seen as a useful tool to get to know the patient situation on admission, and to tailor care plans to patients' individual needs. Regular follow-up meetings during hospitalisation were perceived to provide a relational continuity and to ensure proactive preparation of the family for the post-discharge phase. The involvement of family members, particularly parents, in the care of their (premature or ill) newborn through encouraging, informing and guiding, was considered an essential strength for the planned practice change. Interprofessional, coordinated care was also considered a strength, as was the hospital's primary nursing approach.

Weaknesses were also identified. Predominant among them was the lack of continuity of care in terms of processes and professionals. The professionals identified poor or inconsistent communication from admission to discharge as a further weakness. Differences within teams in practice cultures and attitudes towards families were also considered as a weakness due to the amount of time that was needed to resolve differences in care approaches. Another weakness identified was the prevailing view among professionals that they are the experts and know what is best for patients and families.

Healthcare professionals felt that the move to family systems nursing and care was a welcome opportunity to increase quality of care by introducing a clearly structured process for involving and communicating with families from admission to discharge. They also saw an opportunity to increase

collaborative care and to establish a shared culture of and attitudes towards families and family care. A perceived threat of the practice change was the prevailing concern that introducing family systems care and working with family groups would require more time and increased paperwork in an environment that already faced significant time and workload pressures. Furthermore, professionals feared that other quality and specialty-specific initiatives would be considered more important than introducing family systems care, and given priority. Finally, cultural diversity, language barriers and culture-specific family needs and practices were seen as a major hurdle in engaging families, as these were perceived to require in-depth knowledge around heritage and cultural traditions and sensitivities.

Analysis of patient records showed that in 85% of the cases, relationship status and contact details of a family member or next-of-kin were recorded in the nursing intake assessment. However, in only 16% of these cases was family member input into follow-up assessments, decision making or care delivery evident. Furthermore, in little over 50% of cases were family members involved in discharge planning, and in only 41% of cases were details of caregiving support after discharge documented.

The reviewed literature highlighted as essential the circular, participatory approach to the project to translate family nursing knowledge and skills into practice. It also supported the chosen action research methodology and the strategies outlined in the action plan. Recommended knowledge translation strategies were close, circular collaboration among core group members and practitioners as peers, the provision of useful tools to support working with families, and an ongoing refinement of family nursing skills together with ritualised, regular reflection on family nursing practice (Martinez et al., 2007; Duhamel et al., 2015). Moreover, a combination of educational and training activities was recommended for translating family systems nursing into practice (Svavarsdottir et al., 2015). Intervention strategies, such as asking questions that invite family narratives, and active questioning that enables families to define their healthcare challenge, were shown as positive influences on families' wellbeing and capacity to manage their situation (Manley and McCormack, 2003).

'Think' phase: co-creating family systems nursing purposes, approaches and strategies

The findings from the SWOT and documentary analyses, together with the consultation of pertinent literature around effects and implementation of family systems nursing, enabled the core group to engage in an ongoing, critical dialogue around how to bring about the envisioned change across the different clinical areas and units. Conducting the SWOT analyses and then discussing the insights gained promoted collaboration among the units and clinical areas, participation of staff in developing momentum for the practice change, discussion of concerns and inclusion of many staff and different professions in the knowledge-to-action project. Each facilitator was challenged to reflect on their own assumptions, values and attitudes around family and family systems nursing and care. Core group members who had also facilitated the SWOT analyses took the synthesised findings back to their clinical area and unit-based, interprofessional teams to invite further discussion around effectuating the envisioned practice change. This enabled an ongoing dialogue between the core group and practitioners, including nurses, midwives and physicians, regarding their current values and beliefs around family care, and possible ways of strengthening their capacity to work with families. In line with principles of practice development, a focus on the positive (strengths and abilities), rather than the negative (problems and deficits) was pursued (McCormack and McCance, 2017).

The core group members then revisited their initial ideas of family systems nursing and care in light of the insights gained from the 'look' phase. They then developed a clinical guideline for family systems care based on the Calgary Family Assessment and Intervention Models (Wright and Bell, 2009; Wright and Leahey, 2013), and adapted it to the needs and concerns identified during the look-phase. They then presented the guideline to three senior physicians representing the clinical areas and to key decision makers within nursing and midwifery to receive their critical input around the appropriateness and feasibility of the guideline.

The guideline included the following premises around family systems nursing and care delivery:

1. An understanding of family as a system that is greater than the sum of its parts
2. The need to build practitioner-family relationships in a respectful, open, and trustful way
3. The centrality of an attitude of benevolent curiosity and impartiality
4. A view of families as experts of their situation who receive professional information and advice when they ask for it
5. A shared decision-making process
6. A purposive appreciation of families' capacities and strategies as a core family intervention

Then, family assessment and intervention processes were defined. Family conversation guides were developed, including a guide for (1) a family intake assessment; (2) family care planning and follow-up conversations; and (3) family discharge planning. A template for the conduct of interprofessional family meetings was also devised, and each profession's role and responsibility in family systems care delivery were defined. Interactions with families, either at each family conversation, point of contact, or across the entire care process, were framed with the four core processes: building a relationship with families; assessment; intervention; and concluding relationship (Wright and Leahey, 2013). Finally, family conversation guides were tailored to clinical areas and patient groups, such as a neonatal, obstetrics and gynaecological care.

In addition to the clinical guide and instruments for the delivery of family systems nursing, case studies from each clinical area were collected by nurses as a basis for teaching-learning family assessment and interventions. These cases were gathered in response to the need for narratives to depict practice changes. The 'think' phase also highlighted the importance of using data around current care practices, coupled with practice examples, to build a case for the desired practice change towards proactive partnering with and involvement of families.

To instil a sense of community and to promote a shared culture of family engagement and support across clinical area and professions, a family logo (see Figure 1) was created in collaboration with an artist (albertine.ch/atelier). This increased the recognition and identification among health professionals of family systems nursing and care.

Figure 1: Family logo

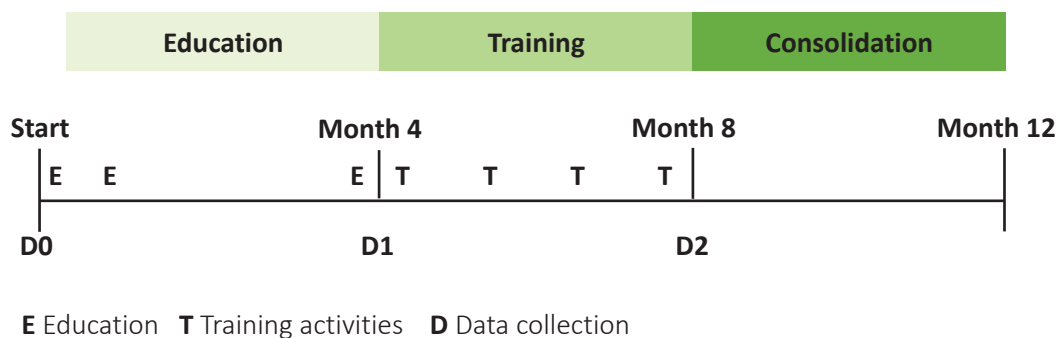


Finally, a communication and implementation plan was devised, drawing on research around family systems nursing implementation (Martinez et al., 2007; Sveinbjarnardottir et al., 2011; Blöndal et al., 2014; Svavarsdottir et al., 2015) and the insights from the 'look' phase. The core group developed an eight-month long family systems nursing education and training programme.

'Act' phase: building capacity at the point of care

Family systems nursing was piloted on the neonatal intermediate care unit starting at the end of 2016. Within neonatology, a high need exists to engage and involve families in the care of their premature or ill newborn to support transition into parenthood and to strengthen child development and family wellbeing (Gooding et al., 2011; McGrath et al., 2011). The drive to change practice towards family engagement and support was therefore high in this clinical area.

Figure 2: Overview of family systems nursing education and training intervention



An implementation team consisting of core group members and change agents was formed, including nurses and one physician. Implementation occurred through education and training activities over a period of eight months before transitioning into consolidation (see Figure 2). During the first four months, nurses and physicians participated in three afternoon educational workshops on family systems nursing and care. Each workshop was held four times to enable all team members to receive the education. The first workshop introduced family systems nursing as an approach to care, while the second and third focused on family assessment and intervention processes, including relational and communication skills (see Table 3). After the second workshop, interprofessional tandems (nurses/physicians) started to conduct family intake meetings together. During the third workshop, participants reflected on their experiences of conducting shared family meetings, and communication skills were discussed and practised.

Table 3: Content of family systems nursing educational workshops

Workshop	Educational content
Introduction into family systems nursing	<ul style="list-style-type: none"> • Family definitions • Sociodemographic overview of families • Systems-orientation and life-cycle perspective in family nursing • Principles, assessment and intervention processes of the Calgary Family Intervention and Assessment Models (CFAM/CFIM)
Introduction and skill training in family conversations	<ul style="list-style-type: none"> • Using the core principles of CFAM/CFIM to guide practise with families (taking a stance of openness, supporting the family's ability in everyday coping and self-care, attending to the quality of life of the family and its individual members) • Applying CFAM/CFIM core processes when working with families (building a relationship with the family, getting to know the family, offering family interventions, concluding the relationship) • Conducting a structured family assessment • Using strength-oriented, interventional and circular questions in supportive interventions with families • Practising family conversations using the family conversation guides (intake family conversation/assessment guide, discharge family conversation, and so on) • Learning about the evidence-base around family systems nursing
Reflection on own practice and communication skills	<ul style="list-style-type: none"> • Sharing and reflecting on experiences with family conversations • Reviewing and extending content of previous sessions • Synthesising core communication principles and strategies when working with families • Devising an action plan for unit-based implementation

During pilot implementation on the neonatal intermediate care unit, a total of 42 neonatal nurses were trained; 28 took part in all three classes, 10 in two classes, and four in one class only. Eight physicians also participated, of which three completed all classes, three more participated in two classes and two did one class only. Reasons given for non-participation were workload or staff absences. Where possible, those who had missed a workshop were invited to complete all educational activities at a later date to enable them to develop the necessary knowledge and skills and to ensure consistent uptake in practice.

The educational workshops were followed by a four-month phase of training activities, including reflective practice sessions (n=5), a review of case studies (n=13), one-to-one coaching and peer feedback (n=5). These training activities aimed to enhance confidence and skills in working with families using the learned relational systems approach during the educational phase. Moreover, regular team reflections took place to support the change from an individual to a systemic practice focus.

Implementation was investigated with a mixed-method study that aimed to examine the effects of the education and training intervention on health professionals' attitudes and skills in respect of working with families, and to explore their implementation experience (Naef et al., in press). Findings will be reported elsewhere. Subsequently, family systems nursing and care implementation were rolled out to the neonatal intensive care units in spring 2017, and to obstetrics and gynaecology in 2018.

Discussion

This article reports on a knowledge-to-action project that aimed to enable the translation of family systems nursing knowledge into clinical practice within the department of women's health in an acute care hospital. At its centre was the transformation of a culture focused on individuals to one that is focused on relational connections – on family as the recipient of care (Manley et al., 2014). To enable a shared, inclusive process of transformation across the three involved clinical areas and healthcare professions, a participatory action methodology with the cycles of look-think-act (Stringer, 2013) was used, along with principles of practice development within nursing (McCormack et al., 2013).

The inclusion of diverse practice cultures, different clinical areas and several professions (nurses, midwives, physicians) in a single initiative was a significant challenge and difficult to manage. While a shared practice culture evolved as desirable during the 'look' phase, particularly because women often move between clinical areas within one inpatient stay, diverging priorities between clinical areas and different cultures among professions needed to be worked with. The particularities of unit-based team cultures had to be incorporated without losing sight of the overall aim of the change process. Wilson (2011) reported a similar struggle in promoting a family-centred care philosophy, where differences among team members led to flaring tensions and ineffective team culture. In our project, competing interests and resistance sometimes slowed down the initiative. A conscious leadership effort was necessary to sustain the initiative across the entire women's health department.

What proved essential in building momentum for the desired culture change was the push for proactive collaboration across clinical areas and inclusion of as many as possible of the healthcare professionals involved in the culture change. Hence, during the 'look' phase, more than 300 professionals were included in the SWOT analyses. Nonetheless, it was challenging to keep them all engaged as we moved into the 'think' phase, and the use of a core group with members representing different clinical areas and professions proved useful and necessary. Core group members not only acted as family systems nursing facilitators in their clinical area, but worked out a set of shared values and rules that guided the initiative and their collaboration (McCormack and McCance, 2006). The action plan that sketched an agreed road towards translating family systems nursing and care was a useful tool that made the change process transparent and tangible, both for the core group and for internal and external stakeholders in the change process (Dewing, 2010). The family logo became a strong conveyor of a culture focused on relational connectedness; that is, relations within families and relationships between families and practitioners, and could be identified with by all clinical areas and professions.

Ongoing communication and feeding back of insights gained during each phase, particularly the 'look' and 'think' phases, invited unit-based team reflections and mutual learning around families' engagement in care. Dialogue and communication are key strategies in organisational transformation and learning (Simoes and Epositos, 2014; van Lieshout, 2015). Reports from similar projects have demonstrated the need for communication opportunities in order to develop a shared vision and enhance collaboration (McCormack and Titchen, 2006; Ådnøy Eriksen and Heimestøl, 2017). Hence, an inclusive, critical dialogue among core group members and between the core group, leadership teams and practitioners across clinical areas allowed shared values to begin developing around working with families, and resulted in a readiness to engage in the change process across clinical areas. Despite the core group's efforts to work in collaborative, inclusive and participatory ways (McCormack et al., 2013) with representatives of the clinical areas and professions in conceptualising and then implementing family systems nursing and care, sustaining engagement in the practice change was challenging.

The role of the facilitators was vital. The core group acted as an energy source that sustained the momentum and, as facilitators, they acted as role models within their professions and in collaborative practices. Facilitation emerged as the main conduit that allowed the energy of culture change to flow across clinical areas. Research has demonstrated that skilled facilitation is key to success (Wilson, 2011; Dahl et al., 2018). Facilitation has been defined as 'the helping of others to change their current situation' (Harvey et al., 2002, p 173), and as a holistic means of enabling practitioner emancipation, development of self and effective workplace cultures (van Lieshout, 2015). Core group members' expertise in family systems nursing and care delivery, and facilitation skills played a key role in enabling the move towards a consistent relational engagement and systemic interventions with families, but varied among clinical areas. A conscious effort to develop skilled facilitation is needed to enable adoption of culture changes and the incorporation of family systems nursing knowledge into everyday working.

The use of look-think-act phases emerged as valuable, as it created the opportunity for collaboration, inclusion and participation, which are core values in developing practice towards a desired, and

agreed aim (McCormack et al., 2007). The 'look' phase took more than a year to complete – time well spent, as it enabled core group members to form alliances with unit-based teams and to learn about their concerns and hopes (Dewing, 2008). While the SWOT analyses revealed a shared commitment towards person- and family-centred care and a wish to increase quality of services to families, health professionals were apprehensive about a potential increase in workload and having to let go of decision-making power. This is consistent with research that has demonstrated similar barriers (Wilson, 2011; Boztepe and Kerimoğlu Yıldız, 2017). Documentary analysis showed low levels of documented family involvement in intake assessment, follow-up conversations and discharge planning, which reveals that a systematic and conscious focus on and engagement with families during the entire hospitalisation period was not yet taking place. The 'look' phase thus confirmed the need to move towards more inclusive and engaging practices with families, and brought to the fore an openness to change based on a commitment to quality care, but also fears around a loss of control, additional workload, and the lack of a supportive organisational context.

During the 'think' phase, an iterative, cyclic process of adopting and integrating the chosen family nursing model (Wright and Leahey, 2013) into the department's system of care delivery was important. Contextualising evidence has been described as key for successful implementation of evidence-based practice in a variety of settings (Bunn et al., 2015; Solnes Miltenburg et al., 2017). The Calgary Family Assessment and Intervention Models (Wright and Leahy, 2013) were integrated into existing and supportive approaches to care, such as primary nursing. The actual translation start of the family systems nursing approach and practises occurred later than intended. Changes in senior nursing leadership and in the project leadership, coupled with staff shortages and high turnover challenged the feasibility of adopting family systems nursing, and in particular of disseminating and consolidating family systems nursing following the educational intervention. Due to the fact that the commitment to the practice change was upheld and shared among nurses, midwives and physicians, the implementation team forged a way forward despite these challenges. In adopting family systems nursing, they experienced fluctuation, which has been described as a normal, highly dynamic process of developing practice. Dahl and colleagues (2018) reported that fluctuation and shifts in staff's enthusiasm to adopt new knowledge is influenced by workplace culture, current workload, and patient responses. Despite the manifold challenges around the diversity of clinical settings and leadership changes, family systems nursing implementation continued and was eventually scaled up across the entire department, primarily within nursing and midwifery.

Conclusions

This article has illustrated the use of an action research methodology coupled with practice development principles to guide the development of a family-centred culture and the translation of family systems nursing knowledge across an entire department in a large university hospital in Switzerland. It reported on the strategies used and experiential insights gained during the look-think-act phases, and briefly described the piloting; formal evaluation of implementation strategies and outcomes will be reported elsewhere. During the knowledge-to-action process, collaboration, communication and facilitation, together with sustained leadership support, enabled a move towards a family-centred culture. Nonetheless, change of practice was marked by fluctuation and hampered by organisational challenges, such as leadership changes and shifting priorities. More local and contextualised family systems nursing knowledge translation strategies, embedded in an overall move towards a family-centred care culture, might have given health professionals greater control over the change process and increased their ability to tailor family systems nursing and care delivery to the particular needs of the families they serve. Hence, smaller-scale initiatives may allow for an increased sense of ownership among stakeholders.

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Acknowledgements

We would like to thank Ursula Böhme, Maya Christen, Dr. Tanja Karen, Sabine Kruse, Barbara Meier Käppeli and Barbara Zürcher for their continued support in moving family-centred care forward. Also, we would like to offer special thanks to Barbara Preusse-Bleuler for contributing her expertise and advice to the project.

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